RIVER CITIES EAR, NOSE & THROAT SPECIALISTS

Today's Date__________________

Name____ Date of Birth________________

CHIEF COMPLAINT

Reason For Today's Visit____
____
____

PAST MEDICAL HISTORY

What medical problems do you have?

( ) High blood pressure
( ) Diabetes
( ) Stroke
( ) COPD
( ) Congestive heart failure
( ) Epilepsy
( ) Cancer
( ) Others________________________________

Are you allergic to any medications? ( ) yes ( ) no
If yes, list the medications.
____

List all the medications you are presently taking. Include birth control pills and vitamins if you take them: ____
____

List all surgeries and when they were performed: ____
____

FAMILY HISTORY

Do you have a family history of the following?

( ) hypertension
( ) diabetes
( ) hay fever
( ) heart disease
( ) others ____
( ) stroke
( ) cancer
( ) TB
( ) hepatitis
( ) thyroid disease
( ) asthma
( ) free bleeding
( ) hearing loss

SOCIAL HISTORY

Smoking ☐ Yes ☐ NO How much?__________________ How many years?______________
Please Circle: cigar pipe chewing tobacco cigarettes used to smoke
Do you consume Alcoholic beverages? ☐ Yes ☐No If yes, how much? ______________________
Do you experiment with drugs? ☐Yes ☐ No
Do you use caffeine products? ☐ Yes ☐ No If yes, How much?__________________________

REVIEW OF SYSTEMS

Do you have or have you had any of the following:

EARS, NOSE, THROAT AND MOUTH: (Please circle) nose bleed, smelling problems, tonsillitis, ear ache, hoarseness, nasal drainage, swallowing difficulty; Other:____
Explain:____

CARDIOVASCULAR: (Please circle) chest pain, blood pressure problems, heart attack, high cholesterol; Other ______________________ Explain ____

LUNGS: (Please circle): chronic cough, asthma, emphysema, bloody sputum, shortness of breath;
Other________________________Explain ____

GASTROINTESTINAL: (Please circle): indigestion, hiatal hernia, bleeding stool, jaundice;
Other ________________Explain ____

GENITOURINARY: (Please circle): trouble urinating, kidney stones; Other _______________________
Explain ____

NEUROLOGICAL AND MUSCULOSKELTAL: (Please circle): arthritis, weakness, paralysis, headache, double vision, stroke, anxiety; Other __________________Explain ______________________________

HEMATOLOGY AND OTHERS: (Please circle) anemia, allergy, bleeding tendency; Other____________
Explain ____

ENDOCRINOLOGY: (Please circle): diabetes, hormonal problems; Other_________________________
Explain____

The above information is accurate to the best of my knowledge.

______________________________________ _______________________
Patient Signature Date

I have reviewed the above information with the patient.

______________________________________ _______________________
Physician Date